



MILES COLLEGE

P. O. Box 3800
Birmingham, Alabama 35208

MEDICAL EXAMINATION FORM

Name: _____ SSN: _____
Last First Middle

Address: _____
Street Apt/Building #

City State Zip Code

Telephone: () _____ Date of Birth: ____/____/____
Month Day Year

1. Record of illness: (Check those which occurred within the past five (5) years):

Frequent colds	___	Allergies	___	Bone Disease	___
Influenza	___	Chickenpox	___	Skin Disease	___
Bronchitis	___	Hernia	___	Diabetes	___
Pneumonia	___	Hypertension	___	Kidney Disease	___
Tuberculosis	___	Rheumatic Fever	___	Other:	___
				Specify	_____

2. Have you had any of the following to occur? (Check those which occurred within the past 5 years).

Blurred Vision	___	Leg Pains	___	Nosebleed	___
Recurring Headaches	___	Chest Pain	___	Palpitation	___
Fainting Spells	___	Shortness of Breath	___	Sore Throat	___
Painful Joints	___	Frequent Urination	___	Abdominal Pain	___
Backaches	___	Painful Urination	___	Jaundice	___
Constipation	___	Cough (prolonged)	___	Vomiting	___

3. The Alabama School Immunization Law enacted in 1974 and the 1990 addendum require that each student at the time of entrance to college must show proof of second vaccination against all vaccine-preventable disease. Please attach a copy of your immunization record, including dates of immunization. You cannot be admitted to Miles College without this immunization record.

4. Physical Examination:

Height: _____	Weight: _____	LUNGS: _____
Blood Pressure: _____	Heart Rate: _____	EXTREMITIES: _____
HEENT: _____	ABDOMEN: _____	HEART: _____
NECK: _____	GU: _____	NEURO: _____

5. LABS:

A. <u>CBC</u>	B. <u>Urine</u>	C. <u>Blood Glucose</u> _____
WBC _____	Specific Gravity _____	
HGB _____	Sugar _____	
HCT _____	Protein _____	

6. Drug Allergies: _____

7. Recommendations: _____

Physician's Signature

Date